DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO AN ALLEGATION OF PHYSICAL ABUSE

A forty-two year-old, mentally retarded, male client at the Central Virginia Training Center in Lynchburg, Virginia, allegedly physically abused at CVTC

DRVD CASE# 98-0087 DD
Department For Rights of Virginians With Disabilities
Fishersville Field Office
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I. INTRODUCTION

This report is a summary of the findings from an investigation conducted by the Department for Rights of Virginians With Disabilities (DRVD) into the allegation of physical abuse of PR, a 42 year-old male client of Central Virginia Training Center (CVTC) in Lynchburg, Virginia. PR allegedly sustained an injury to his right shoulder on March 22, 1998. PR's sister, who is his legal guardian, contacted DRVD to investigate the incident as possible abuse.

DRVD conducted this investigation of an alleged incident of abuse and/or neglect of an individual with developmental disabilities pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 1994. The investigation was conducted jointly with the assigned CVTC abuse investigator and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) internal advocate.

The investigation included the following:

1. Review of PR's records at CVTC;
2. Review of CVTC's administrative investigation report;
3. nterviews with PR's direct care staff members at CVTC including, but not limited to, PR's nursing staff, program manager, social worker, third shift supervisors;
4. Discussion with PR's immediate family.

II. THE ALLEGATION

PR's sister, who is also his legal guardian, contacted DRVD on April 13, 1998. She told DRVD staff that PR had sustained a dislocated shoulder on March 22, 1998 at CVTC and she was concerned that someone at CVTC could have abused him. She also expressed concern that a CVTC physician left a message on her answering machine notifying her of the injury and informing her that PR was being transported to Lynchburg General Hospital for medical treatment. PR's sister said that, although she left numerous messages asking the physician to contact her with information concerning PR's medical status, the physician did not return her telephone calls. PR's sister received no further information concerning PR's medical condition until she was contacted by a social worker, approximately a week later, who told her that PR had returned to his living area, Bannister Hall, at CVTC.

III. BACKGROUND

CVTC is a state facility for persons with mental retardation, which is operated by the DMHMRSAS and has a population of approximately 700 clients. PR is a 42 year-old, ambulatory, male diagnosed as Bipolar I Disorder, Rapid Cycling and profoundly mentally retarded. PR has numerous other health problems as well.

IV. CIRCUMSTANCES SURROUNDING THE INCIDENT

At approximately 12:30 a.m. on March 22, 1998, a third-shift Human Services Care Worker (HSCW) who accompanied PR to the bathroom noticed that "something wasn't right" with his right arm. Although she called for a co-worker to look at PR's arm when she first observed that something was wrong, the HSCW did not report that PR's right arm appeared limp until the first shift staff arrived at Bannister Hall at 6:45 a.m. When first shift arrived at Bannister Hall, the third shift HSCW documented her observations in an Interdisciplinary Note in PR's medical record and told a first shift HSCW lead worker to have PR's arm checked by the unit nurse.

When the first shift HSCW lead worker checked PR's arm at 9:45 a.m. she noted that it was "still limp" and she notified the registered nurse on duty that PR's arm needed to be examined. The registered nurse inspected PR's right arm at 10:10 a.m. and noted in PR's medical record that, although PR's arm was not red or swollen, it appeared that his arm was in an awkward position and PR acted as though it hurt if he tried to raise his arm. After examining PR's arm, the registered nurse notified the CVTC physician, and PR was sent to the CVTC medical clinic.

The physician examined PR and x-rays revealed that PR's shoulder was dislocated. PR was transported to Lynchburg General Hospital's Emergency Room at 11:10 a.m., after being administered 100 mg. Motrin for pain,. PR was examined and treated at Lynchburg General Hospital, and he returned to his living area at 3:30 p.m. with a shoulder immobilizer. Upon his return to Bannister Hall, a food tray was ordered for PR and his medical record indicates that he ate and drank well and sat "quietly" in the day hall afterwards.

V. FINDINGS AND CONCLUSIONS

This investigation included review of PR's medical record and interviews of PR, the first-shift HSCW, the registered nurse who first examined PR, the assistant program manager, the Bannister Hall social worker and a review of the transcripts of the CVTC internal investigator and DMHMRSAS internal advocate's interviews of the third-shift HSCWs who first noticed client's condition. There was nothing documented in PR's medical record or disclosed in the interviews to substantiate how PR's shoulder became dislocated or to substantiate an allegation of abuse. Based on this information, it appears that no one at CVTC assumed responsibility for attempting to determine the cause of the dislocation of PR's shoulder.

The *CVTC Policy Manual* was also reviewed as part of the investigation. CVTC has no policy that required the third-shift HSCW to seek timely medical services for PR when she noticed that "something wasn't right" with his arm. Ten hours passed from the time that the third-shift HSCW made that observation and the time that PR's shoulder was examined by the CVTC registered nurse. Eleven hours passed before he was transported to the hospital to receive care. The delay in seeking medical intervention for PR was clearly neglect.

Review of the *CVTC Policy Manual* also reveals that CVTC has no policy that requires a CVTC physician to speak directly with a client's legal guardian when conveying a change in medical status that has resulted in hospitalization, to provide a client's legal guardian with periodic updates when a client's condition suddenly requires hospitalization, or to return telephone calls from a client's legal guardian in a timely manner.

VII. RECOMMENDATIONS

The following recommendations are suggested based on the findings and conclusions of this investigation:

1. CVTC should develop a policy requiring direct care staff to be responsible for documenting their attempts to determine the source of all injury(ies) to clients in their care.
2. CVTC should develop a policy requiring any staff person who notices a possible change in a client's medical condition to seek timely medical services for that client.
3. CVTC should develop a policy that requires a CVTC physician to have direct contact with a client's legal guardian when the client has undergone a change in medical status necessitating hospitalization. The policy should require the physician to provide reasonable, periodic updates on the client's condition to the legal guardian, or, in the alternative, require the physician to return telephone calls from the client's legal guardian within a reasonable period of time to discuss the client's medical condition.